

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41160**

Registration District No. **114**

Primary Registration District No. **30.35**

Registrar's No. **65**

1. PLACE OF DEATH:

(a) County **Lafayette**  
(b) City or town **Lexington**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **All Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

**James H. Washington**  
(b) If veteran, name war **0** (c) Social Security No. **0**

4. Sex **Male** 5. Color or race **2 Negro** 6. (a) Single, widowed, married, divorced **Single**  
(b) Name of husband or wife **0** (c) Age of husband or wife if alive **0** years  
7. Birth date of deceased **May 8, 1902** (Month) (Day) (Year)

8. AGE: Years **40** Months **6** Days **7** If less than one day hr. min.

9. Birthplace **Lexington Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Robert Black**

11. Industry or business **Barber Shop**

12. Name **James Washington**  
13. Birthplace **Lafayette Co. Mo** (City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Walker**  
15. Birthplace **Lafayette Co. Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Salvatore Robinson**

(b) Address **Lexington Mo**

17. (a) **Burial** (b) Date thereof **Nov. 16, 1943** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lexington Mo**

18. (a) Signature of funeral director **Winkler**

(b) Address **Lexington Mo**

19. (a) **11-16-42** (b) **Mrs. Fred Schwab** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**  
(c) City or town **Lexington** (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) **0**  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **15** year **1942** hour **11 A** minute **0** M.

21. I hereby certify that I attended the deceased from **called in** **Dr. J. H. Gault** to Coroner **19** that I last saw him **alive on** **19** and that death occurred on the date and hour stated above.

Immediate cause of death **0 Pulmonary embolism**  
**dropped dead on street**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **0 cerebral clot lodged in pulmonary valve**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Dr. J. H. Gault** (M. D. or other) **0**  
Address **0** Date signed **11-15-42**

**11-15-42** (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1946 JAN 11

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 12-16-42

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Harriet J. Gumpel*

Licensed Embalmer No.

3275

P. O. Address

*Luxington, Me*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.